



Centre for Pediatric Development and Adult Health

Pregnancy History Form

Name: _____

Birth Practitioners: Midwives Name: _____
Doula Name: _____
Medical Practitioners Name: _____

Your Estimated Due Date: _____

Choice of Birth Place: Home: _____
Hospital: _____

Is this your first pregnancy? Yes No _____
Number of previous pregnancies: _____ Number of Children: _____

Have you used fertility treatments? Yes No _____

Have you experienced any traumas during this pregnancy? (Please include any accidents or falls)

Have you had any evaluation procedures: (Please share your reasons for choosing these procedures, frequency and effects)

Ultrasound: _____

Amniocentesis: _____

Chorionic Villus Sampling: _____

Other: _____

Is this pregnancy being treated as high-risk? Yes No If so, why?

Have there been any stressful events in you life during this pregnancy?



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Previous Births History

Were fertility methods used? Yes No _____.

At what week of pregnancy were your previous babies born? _____

Previous Practitioners: Midwives Name: _____

Doula Name: _____

Medical Practitioners Name: _____

Previous Choice of Birth Place: Home: _____

Hospital: _____

Who attended your births? _____.

Please circle all that pertain to your previous births: Vaginal delivery c-section back labour
epidural episiotomy induction forceps vacuum posterior presentation breech baby presentation
Other: _____

Previous Birthing positions: Lithotomy (on back with feet up) Squatting On all fours Side

Lying Birth stool Birthing water tub

Other: _____

Did your babies experience any of the following: Premature Birth Neonatal ICU

Low APGAR Scores Low Birth Weight Failure to Thrive Colic Breathing Difficulties

Allergies Breastfeeding Difficulties Formula-fed Developmental Delays

Other: _____
